STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  (X3) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  (X4) ID PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  (X5) MULTIPLE CONSTRUCTION  (X3) DATE SURVEY COMPLETED  (X4) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE  (X4) ID PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  (X5) MULTIPLE CONSTRUCTION  (X5) MULTIPLE CONSTRUCTION  (X5) DATE SURVEY COMPLETED  (X4) ID PROVIDER'S PLAN OF CORRECTION  (X5) DATE SURVEY COMPLETED  (X6) MULTIPLE CONSTRUCTION  (X5) DATE SURVEY COMPLETED  (X6) MULTIPLE CONSTRUCTION  (X6) DATE SURVEY COMPLETED  (X7) MULTIPLE CONSTRUCTION  (X7) DATE SURVEY COMPLETED  (X7) MULTIPLE CONSTRUCTION  (X8) DATE SURVEY COMPLETED  (X8) DATE SURVEY COMPLETED  (X8) DATE SURVEY COMPLETED  (X1) DATE SURVEY COMPLETED  (X2) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (	DEPARTMENT OF HEALTH AND HUMAN SERVICES								PRINTED: 10/10/2012 FORM APPROVED		
AA5358  NAME OF PROVIDER OR SUPPLIER  LAKEBRIDGE HEALTH CARE CENTER  (X4) ID PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  CARE CENTER  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 115 WOODLAWN DRIVE  JOHNSON CITY, TN 37604  PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  CAMPLE TO THE APPROPRIATE DATE  CARE CENTER  COMPLETED  (X3) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETED  OAT  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  CARE CENTER  CARE CENTER  COMPLETED  OAT  OAT  COMPLETED  A. BUILDING  STREET ADDRESS, CITY, STATE, ZIP CODE 115 WOODLAWN DRIVE  JOHNSON CITY, TN 37604  (EACH CORRECTION SHOULD BE COMPLETED  OAT  OAT  COMPLETED  OAT  OAT  CACH CORRECTION  COMPLETED  OAT  OAT  CACH CORRECTION  COMPLETED  OAT  OAT  OAT  OAT  CACH CORRECTION  CACH CORRECTION  CACH CORRECTION  CACH CACH CORRECTION  CACH CACH CORRECTION  CACH CACH CACH CACH CACH CACH CACH CAC	CENTE	RS FOR MEDICARE						(			
NAME OF PROVIDER OR SUPPLIER  LAKEBRIDGE HEALTH CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 115 WOODLAWN DRIVE JOHNSON CITY, TN 37604  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  Complaint investigation #28984, #29096, and #29558, were completed at Lakebridge Health Care Center on October 4, 2012. No deficiencies were cited under 42 CFR Part 483, Requirements	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY			
LAKEBRIDGE HEALTH CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  115 WOODLAWN DRIVE  JOHNSON CITY, TN 37604   (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  Complaint investigation #28984, #29096, and #29558, were completed at Lakebridge Health Care Center on October 4, 2012. No deficiencies were cited under 42 CFR Part 483, Requirements	445358			B. WING							
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F 000 INITIAL COMMENTS  Complaint investigation #28984, #29096, and #29558, were completed at Lakebridge Health Care Center on October 4, 2012. No deficiencies were cited under 42 CFR Part 483, Requirements	LAKEBRIDGE HEALTH CARE CENTER					115 WOODLAWN DRIVE					
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		#29558, were comp Care Center on Oct were cited under 42	leted at Lakebridge Health ober 4, 2012. No deficiencies CFR Part 483, Requirements								

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 10/10/2012